

analysis suggests medical treatment is safe for chronic anal fissure and reserves surgery for treatment failure.

Method: This observational study over 2 years analysed outcome measures on patient symptoms and QOL scores. The QOL scores were recorded before and after respective procedure using SF 36 QOL Assessment Form.

Result: The median age was 48(28–77) years. 95.83% patients completed the SF-36 form. This revealed that their quality of life improved significantly in physical functioning, pain, social functioning and mental health.

Conclusion: QOL data is rarely acquired in surgery so adds new knowledge to the study by using available tools to assess QOL in patients undergoing surgical treatment. Our study shows improvement in the QOL in patients treated with Botox for chronic anal fissure at follow up.

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0830: EXTENDED VTE PROPHYLAXIS AFTER COLORECTAL CANCER SURGERY – WHERE'S THE EVIDENCE?

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Background: NICE recommends extending pharmacological thromboprophylaxis to 28-days postoperatively following abdominopelvic cancer surgery. This is based on a 2009 Cochrane Review, which used data over a decade old and compared extended thromboprophylaxis with placebo. In current practice, where a minimum of in-hospital pharmacological thromboprophylaxis is standard, is there evidence to support extended prophylaxis following colorectal cancer surgery?

Aim: To report current incidence of post-discharge symptomatic VTE in patients receiving only in-hospital pharmacological thromboprophylaxis after colorectal cancer surgery.

Method: Two reviewers conducted a systematic review of the PubMed Database using PRISMA guidelines. To ensure assessment of contemporary data, only articles published after the 2009 Cochrane Review were included.

Result: Initial search identified 50 abstracts. Final analysis included four articles: one RCT and three retrospective cohorts. Data for 682 patients revealed an incidence of 0.7% post-discharge symptomatic VTE at 30-days post colorectal cancer surgery.

Conclusion: Current evidence suggests low incidence of post-discharge symptomatic VTE following colorectal cancer surgery. The benefit of extending thromboprophylaxis is therefore questionable. In-hospital thromboprophylaxis, enhanced recovery protocols and modern surgical techniques have likely out-dated the evidence upon which national recommendations are based. A well-powered RCT comparing in-hospital with extended thromboprophylaxis is necessary to inform revised national recommendations.

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0871: EFFECTIVENESS OF THE BRITISH SOCIETY OF GASTROENTEROLOGY GUIDELINES FOR SURVEILLANCE COLONOSCOPIES ON COLONIC ADENOMAS

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Introduction: The British Society of Gastroenterology (BSG) has set clear guidelines on surveillance colonoscopy for adenomatous polyps. This study aims to determine if these guidelines were adhered to in an accredited unit.

Method: All patients who underwent surveillance colonoscopies between October 2014 and 2015 were retrospectively included. Information relating to polyp number, size, and histology were collected and their subsequent schedule colonoscopy was then compared with the BSG guidelines.

Result: Out of the 106 cases detected, 62% (66/106) were not compliant to the BSG guidelines ($p > 0.05$). 49% (52/106) of the cases were requested by gastroenterology of which 62% (32/52) were not compliant to the BSG guidelines and on average were requested 35.4 months earlier than scheduled. 51% (54/106) of the cases were requested by surgery of which 59% (32/54) were not compliant to the BSG guidelines and on average were requested 36.5 months earlier than scheduled.

Conclusion: Too many surveillance colonoscopies were performed in our unit and in around 60% cases nearly three years earlier than required. Targeting the reasons for non-compliance could potentially reduce workload and improve efficiency in an over-stretched colonoscopy unit.

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0883: OUTCOMES OF EMERGENCY LAPAROSCOPIC COLONIC RESECTION: A SINGLE CENTRE EXPERIENCE

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Introduction: Laparoscopic colonic resection in the emergency setting has not been met with comparable enthusiasm as that in the elective setting. We describe the 5-year experience of emergency laparoscopic colonic resection at a single colorectal unit.

Method: Data for emergency laparoscopic colonic resections was collected from a prospectively-maintained database for a single surgeon at a colorectal unit between 2010–2015. Outcomes were compared to average data for emergency open colonic resection within the department.

Result: A total of 66 patients were included in this study with a median age of 62 years. Average operating time was 190 minutes (compared to 144 minutes for open emergency resections). The conversion rate to open resection was 9%. Intraoperative complications occurred in 6% of cases and included bleeding and bowel injury. Postoperative complications (30-day) were mainly infective and occurred in 13.6% of cases. No anastomotic leaks were identified in this cohort. Median postoperative stay was 6 days compared to 7 days for open surgery. For malignant colonic pathology, R1 resections occurred in 9.5% of cases and median lymph node yield was 20.

Conclusion: Our data confirms the feasibility and safety of colonic resection surgery in the emergency setting for benign and malignant disease.

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0910: THE INCIDENCE AND IMPLICATIONS OF INTESTINAL INJURY IN LAPAROSCOPIC COLORECTAL SURGERY

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Aim: Intestinal injury (II) is a recognised complication of laparoscopic surgery in general, there is little evidence on the actual incidence of II in laparoscopic colorectal surgery (LCS). This study investigates the incidence and consequences of II in LCS.

Method: A systematic literature search was conducted through PubMed, Ovid, and the Cochrane Database to identify primary studies in the English Language which reported incidence of II in LCS for benign and malignant diseases between January 2000 and October 2015. Information on demographics, operative characteristics, previous abdominal surgery, conversion rate, and II was extracted from the selected studies.

Result: Forty-three studies were included, pertaining to 29600 patients. The overall intra-operative complication rate was 5.7% ($n = 1297/22931$), conversion rate was 8.6% ($n = 2351/27368$), and mortality rate was 1.0% ($n = 297/28943$).

II occurred in 365 patients (1.2%) and forms 28.1% of all intra-operative complications. The majority of injuries were diagnosed intra-operatively (98.6%, $n = 360$), of which 11.4% ($n = 41$) required conversion to open surgery. Among the 1.4% ($n = 5$) of II diagnosed post-operatively, 60% ($n = 3$) died.